Center for
Healthcare Improvement for
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Chronic Care Management Intervention: A Qualitative Analysis of Key Informant Accounts

Meg Cristofalo, MSW, MPA, Toni Krupski, PhD, Lindsay Jenkins, MPH, MPA, Alicia Yee, BA,
David Atkins, PhD, Imara West, MPH, and Peter Roy-Byrne, MD
Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable
Populations (CHAMMP)
Department of Psychiatry and Behavioral Sciences
University of Washington at Harborview Medical Center
Seattle, Washington

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Beverly Court, PhD
Contract Manager

Executive Summary

The Rethinking Care Project

Rethinking Care (RTC) is a program funded by the Washington State Health and Recovery Services Administration (HRSA) within the state Department of Social and Health Services (DSHS) which began in February, 2009. The program is being carried out in collaboration with the Center for Health Care Strategies (CHCS) and King County Care Partners (KCCP), a partnership of King County Aging and Disability Services (ADS), Harborview Medical Center (HMC), and four community health center networks. Its purpose is to improve the quality and reduce expenditures for Supplemental Security Insurance (SSI) recipients with co-occurring medical and mental health/substance abuse problems by providing care management. The King County Care Partners Program (KCCP) was established in early 2007 by DSHS/HRSA as a predecessor to RTC.

The RTC Program is being carried out as a randomized control trial in order to allow a rigorous evaluation of the program's impact. Approximately 1,560 eligible individuals are expected to be randomly assigned to either the RTC intervention or to a treatment-as-usual abeyance group over a two-year period beginning February 1, 2009. As one part of this broader evaluation, a series of key informant interviews were conducted to better understand the chronic care management intervention and how it changed over time. This report summarizes the results of those interviews.

Intent of the Qualitative Analysis of Key Informant Accounts

The purpose of the analysis is to describe the RTC Program and how it has unfolded since February, 2009. Interviews were conducted with a group of RTC key informants which included program administrators, nurse care managers, social workers, and clinic care coordinators and physicians in the community health center network to inform a descriptive analysis of the intervention and engagement strategies and how these have changed over time.

Findings
- The core element of the RTC Program is nurse-led, multidisciplinary care management executed through the orientation of motivational interviewing. Clients receive a comprehensive assessment, develop self-care goals, receive the support and resources to accomplish their goals and achieve health self-management.

- Key informants identified fundamental components of the RTC intervention.

    o *Care Collaboration*. Engaging with the client's providers or potential providers to facilitate meeting the client's health care needs. This includes accompanying the client to appointments and facilitating the client/provider relationship through advocacy, coaching, modeling, and education.

    o *Care Coordination*. Gathering all of a client's providers, including primary care, specialty care, mental health, and chemical dependency, to get them talking to each other and functioning as a team. System navigation, securing health care,

and assisting clients in meeting their psychosocial needs are part of care coordination.

- o *Health Educatio*n. Providing education about specific diseases along with the skills, concrete tools, and resources for the client to self-manage their illness.

- o *Central Support:* The interface between the client and nurse care manager, characterized by frequent contact, accessibility of the nurse, and access to multiple additional support people.

- Key informants described the primary benefit of the program to clients as gaining the confidence, skills, and resources to navigate the health care system and self-manage their health, as well as the individual benefits from "success stories."

- Intended benefits to the system are cost reduction through decreased emergency department use, crime, and inpatient hospital stays; harm reduction, prevention of more serious illness; and decrease in mortality. There is also an intended benefit of incremental transformation of the health care system through program efforts.

- Key informants identified the following client characteristics as indicators for success in the RTC Program: willingness and motivation to improve health; absence of or less severe mental illness, chemical dependency, or cognitive deficits; less severe medical illness or illness for a shorter period of time; stable social support and housing.

- Physicians do not feel fully informed about the RTC Program. They most appreciate the nurse care manager accompanying their patients to clinic visits, or, "getting patients to appointments". They expressed an understanding of the program reflecting the hierarchical culture of the medical model which diverged somewhat from the collaborative, client-centered RTC philosophy.

- Changes over the course of the initial program through to the RTC iteration include lengthening program and assessment times, adding validated instruments to the assessment, involving clinic care coordinators from the beginning of the intervention, multidisciplinary expansion through social work, bringing the initial outreach in-house, changing eligibility, increasing the focus on mental health and chemical dependency, and providing training in motivational interviewing

- Key informants identified the following challenges in the program
  - o *Programmatic.* Inadequate data system and barriers to cross-institutional communication due to confidentiality significantly impede the program. Large caseloads, inconsistent work flow, lack of adequate technology (e.g. laptop computers), and hazards working in the community are challenges for the nurse care managers and social workers.

- o *Participation*. Unmet basic needs, language/cultural barriers, mental illness, and chemical dependency hinder clients' participation. Finding and contacting clients is difficult.

- o *Providers*. Judgmental attitudes discourage clients. The medical residents and new professionals who care for clients do not have enough experience for their complexities. Appointments are too short. Waiting periods for appointments are too long. The nurses and care managers and social workers experience professional territorialism in the clinics.

- o *Systems*. Lack of access to chemical dependency treatment and the bureaucracy of the mental health system keep clients from progressing.

- Key informants expressed appreciation for the innovative nature of the program, their talented, committed colleagues, strong leadership, successful community partnerships

Recommendations

- ***Multidisciplinary Refinement***. The program has become increasingly multidisciplinary in its execution, with increased focus on psychosocial issues, mental health, and chemical dependency. The nurses and social workers at times work outside their core competencies; nurses address psychosocial, mental health or chemical dependency issues, and social workers perform clerical duties. Providing a framework in which these staff members practice primarily within their professional roles would increase productivity and efficiency. Clerical support is needed. Retaining the central support and leadership of the nurse care manager is important; key informants identified this "go to" person as an essential ingredient of the intervention.

- ***Caseload and Work Flow.*** Nurse care managers gave suggestions of maintaining caseloads between 35 and 50 clients. Consistent, steady case flow and weekly meeting schedule would improve the nurse care managers' and social workers' ability to execute the program efficiently.

- ***Technology***
  - o Laptops the nurse care managers and social workers could take with them in the community, as well as cell phones, would save much time. Global Positioning System (GPS) devices would also help in navigating across the county when they visit clients. These are relatively inexpensive items that could make a significant difference in staff productivity, efficiency, and morale.

  - o Given the challenges in cross-institutional information exchange it would be important to identify ways to share such information. One possibility is to assign client numbers so they do not have to be identified by name in emails.

  - o Clients often lack consistent phone contact due to homelessness, finances, or lifestyle. It would be reasonable to consider the option of giving them disposable

cell phones at any period during which lack of contact would impede successful participation in the program.

- *Data System*
  - o Because the intervention has become increasingly multidisciplinary, equal and flexible access to the initial assessment additional information would help streamline the combined efforts of the nurse care managers and social workers in the most efficient way possible.

  - o Partner clinic physicians indicated that they would like updates on clients. Developing a standard format for client updates as well as a protocol for transmitting this information to physicians and possibly other providers such as mental health and specialists should be considered as an important element of the new data system.

  - o Clinic care coordinators indicated that they would like client summaries at the transition. Developing a standard format for a transition summary should also be considered as a component.

  - o Considering that cross-institutional communication by email is a challenge, creating a data system that allows extensive enough documentation and updates that need for email communication about clients is minimized would cut down on the time and complex strategies nurse care managers, and clinic care coordinators are currently using.

  - o For information and records in which detailed narrative is not necessary or standardization is optimal, providing several options requiring minimal data entry would save time and increase efficiency.

- *Assessment and Evaluation.* Investigating whether there are validated instruments for other languages and populations for the Patient Activation Measure (PAM) and the other assessment instruments and fortifying clinical evaluation by standardizing it would strengthen assessment and evaluation as a whole.

- *Education and Marketing.* More consistent education and marketing about the program, particularly the underlying core concepts of care management and motivational interviewing, would clear up misunderstandings, allowing providers to work in concert with the program and mitigating the professional territorialism the nurse care managers and social workers say they encounter in the clinics.

- *Transition.* Consider standardizing the transition procedure, including provision of formal client summaries for the clinic care coordinators. Given the variability in client needs and the concern of client dependence on the program, consider customizing a protracted transition option that would provide clients who have less social support, or other factors that complicate transition, with incremental steps that more slowly taper

contact while helping to increase the resources or skills they are lacking for successful transition.

- ***Provider Clinics.*** Consider adding the primary care clinics that already see many program clients to the partnership. This would ease burden on the partner clinics and provide more timely service for clients. Consider developing a strategy for accommodating the reality of short provider appointments such as more frequent visits. Provide regular client updates to providers. Developing a standard format as well as a protocol for transmitting this information to providers should be considered as an important element of the new data system.

- ***Future Study and Focus***
    - o   The program intervention is slowly transforming the system as it makes small incremental adaptations in response to the RTC Program and brings together parties from all parts of the health care system for collaboration. It would be fruitful to study this system change and how it is evolving, as it is an essential element of the impact of the intervention and on the cutting edge of health care delivery.

    - o   Considering the difficulties in the mental health system, focus on building mental health integration to reduce some significant client barriers to participation.

    - o   Emergency departments are a significant element of this client population's care. Collaborating and coordinating with emergency departments in a similar way as the program currently collaborates with clinics could add another beneficial layer to the intervention.

    - o   Key informants emphasized the individual nature of clients' accomplishments in the program and spoke about wonderful success stories they hear. Consider collecting and compiling client success stories in a format that can be easily shared with others. Such stories have the potential to powerfully communicate the impact of the program to a broad range of stakeholders.

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I. Introduction and Overview

Rethinking Care (RTC) is a program funded by the Washington State Health and Recovery Services Administration (HRSA) within the state Department of Social and Health Services (DSHS) which began in February, 2009. The program is being carried out in collaboration with the Center for Health Care Strategies (CHCS) and King County Care Partners (KCCP), a partnership of King County Aging and Disability Services (ADS), Harborview Medical Center, and four community health center networks. Its purpose is to improve the quality and reduce expenditures for Supplemental Security Insurance (SSI) recipients with co-occurring medical and mental health/substance abuse problems by providing care management.

The RTC Program is being carried out as a randomized control trial in order to allow a rigorous evaluation of the program's impact. Approximately 1,560 eligible individuals are expected to be randomly assigned to either the RTC intervention or to a treatment-as-usual abeyance group over a two-year period beginning February 1, 2009. As one part of this broader evaluation, a series of key informant interviews were conducted to better understand the chronic care management intervention and how it changed over time. This report summarizes the results of those interviews.

The purpose of the analysis reported here is to describe the RTC Program and how it has unfolded since February, 2009. To do this, we conducted interviews with a group of RTC key informants which included program administrators, nurse care managers, social workers, and clinic care coordinators and physicians in the community health center network.

II. Methods

PARTICIPANTS
We invited four RTC Program administrators including the Medical Director, Clinical Nurse Supervisor, and two ADS administrators to complete individual interviews about their experiences with the program. The clinical supervisor at ADS gave the RTC nurse care managers and social workers the option of participating in one of two group interviews by discipline. The Medical Director introduced the interviewer to several clinic care coordinators and physicians from KCCP clinics who had exposure to the RTC Program. Three clinic care coordinators from three different clinics and three physicians from two different clinics were recruited to participate in individual interviews. No one declined to participate. The research was approved by the Department of Health and Social Services (DSHS) institutional review board (IRB).

PROCEDURE
The interviews were completed during March and April, 2010. They were conducted by a qualitative research interviewer accompanied by a research assistant who took notes on the interview content. Fifteen people participated in the interviews: four administrators, three clinic care coordinators, and three physicians in individual interviews; two social workers in a focus group, and three nurse care managers in another focus group. Focus groups were chosen for the social workers and nurse care managers, who work together at ADS, to enhance the

exploration and clarification of their views through a group process (Kitzinger, 2006). The interviews were conducted at the participants' respective places of employment in private offices or rooms. All interviews were audio taped and transcribed verbatim with verbal consent of all participants. Key informants were told that the interviews and focus groups were confidential, only the CHAMMP research team would see the transcripts, and their names would not be linked with any specific comments they made. The interviewer explained that she would ask questions relating to participants' experiences with the RTC Program to gain a better understanding about it. The semi-structured interview consisted of predominantly open-ended probes and several more specific questions. The majority of questions were placed to all key informants. Several questions were specific to role in the program and were only addressed to certain participants. Interview questions for each particular key informant group can be found in Appendix A. Participants were allowed to speak freely or converse, bringing up their own topics in the process sometimes, but the question sequence was followed faithfully in all the interviews. No questions were ever skipped. Because some of the key informants were involved in an earlier iteration of the program and many interview questions focused on changes as the program progresses, some information is also given about the program prior to February, 2009. Interviews ranged from forty minutes to two hours, with majority of the interviews taking approximately an hour.

DATA ANALYSIS

The research interviewer conducted a thematic analysis (Pope, Ziebland & Mays, 2006) of the interviews with a focus on adherence to text, using Atlas Ti software. This inductive analysis of the entire body of interviews was completed first. Through an iterative process multiple themes and subthemes emerged from this overall analysis. Separate analyses using the framework approach (Pope, Ziebland, Mays, 2006) for some of the more detailed questions were then completed, producing themes and subthemes specific to these questions. All themes that were mentioned several times were given attention, as well as many other themes from the unique points of view of the different roles of key informants in the program. Particular focus was given to themes with the greatest numbers of endorsements by participants.

III. Results

Five major themes or categories emerged from the key informant interviews: Intervention, Changes, Challenges, Facilitators and Satisfaction, and Suggestions for Change. The Intervention theme includes the framework and components of the intervention, its benefits and disadvantages, and the physicians' perception of the intervention which was slightly different than that of the rest of the key informants. The Changes theme is the modifications and adjustments of the program as it has grown and progressed. Challenges include current difficulties programmatically, for clients' participation, with client providers, and with the greater health care system. Facilitators and Satisfaction is the theme that reports what is going well and why those involved love working with the program. Finally key informants made some suggestions for change in the program.

INTERVENTION

Overview of Intervention

Key informants defined a basic framework for the RTC Chronic Care Management intervention, including client population profile, principal components of the program, and fundamentals of the intervention. Appendix B (note that a page reference for each topic will be added on the chart) provides a pictorial diagram of the intervention components and Appendix C provides a flowchart of the process of the intervention.

Care Management. Overall, key informants identified the RTC Program as "care management" or, more specifically, "chronic care management". Care management is a "strengths-based model of consumer-driven care". (Morano & Morano, 2006) The alliance with the health care "safety net" through community partnerships was mentioned as an essential element of the care management.

> "… what King County Care Partners, pretty much to me is that we have a partnership with other clinics and nurses here with ADS that we've developed a team, a safety net of providers to wrap around these patients with chronic health care issues and assist them in meeting their health care goals, and we do that in the context of a partnership." –Clinic Care Coordinator

The multidisciplinary nature of the care management was referenced with great frequency. Key informants characterized it as "nursing led", with "skilled nursing" being a primary if not *the* primary ingredient, but in concert with social work. The "team" of nursing and social work was offered by key informants of every role as a necessary and effective combination for addressing the complex medical and social needs of KCCP clients.

> "… we really have a multidisciplinary team now because we have three nurses, a social worker who has really good skills in chemical dependency and also just brings to bear the social work side … again I think it's, the other aspect of this intervention, the team that's carrying out this work, I would emphasize that it's multidisciplinary."
> -Administrator

> "And I think the skilled nursing component is extremely important … and the social work- I love this combination of the two because it's just refer for the housing, refer for the CD issues. I mean, you're part of it but you don't have to be the primary with that so that you can get onto other health issues and do a clinical component with the client and an education component and sort of be also helping coordinate the other."
> –Nurse Care Manager

Assessment and Self-Care Goals. Key informants distinguished the fundamentals of the RTC intervention as a comprehensive and continual assessment from which clients identify "self-care goals" and then work, with program support, to meet.

From the assessment the nurse care manager ascertains any barriers or instability in a client's life that would prevent pursuing the self-care goals. Based on this knowledge, the first step is

some level of "stabilization" of the client, along with connection to a consistent primary care provider, or "medical home". By performing such a comprehensive assessment, part of which involves the nurse care managers and social workers consulting secondary sources (e.g. medical records), the program can be highly individual for each client.

> "… doing a comprehensive assessment … working with the client to help them set self-care goals using motivational interviewing practices, engaging them in their own health and direction of their health and then connecting them with the medical home if they don't have a medical home, or working with the medical home to find out what are some of the barriers, and making sure that some of those things are addressed."
> -Administrator

From this point the client works in partnership with their nurse care manager, and often a social worker, for a period of up to a year, to pursue their self-care goals and ideally, achieve some level of health self-management and maintenance.

Clients. The clients were typically identified as the "sickest, poorest" individuals in King County. Multiple key informants described the client population as "forgotten".

> "They're the lost and forgotten people. Because their situations are so complex, I think for a very high functioning person it would be difficult and for them it's impossible."
> -Administrator

More specifically, key informants explained that RTC clients are "chronically ill Medicaid patients who also happen to have mental illness and/or a substance abuse disorder" and are "high utilizers of emergency departments". Clients were also routinely depicted as carrying significant medical and social complexity.

> "… have very complex medical regimens and are in and out of ERs or maybe they're not taking their medications or going to their follow-up, so the kind of medical complexity, and then the other types of people that I've interacted with, patients that are on it seem to have very complex social situations, struggle with addiction, alcoholism, drugs, homeless and poor living situations, so that makes the complexities of their chronic care even worse."   -Physician

Motivational Interviewing. According to the key informants, all the fundamentals of the intervention are executed through the lens of motivational interviewing (MI) and the stages of change model, a component of the transtheoretical model of change. MI is a client-centered, directive style used to enhance intrinsic motivation and readiness for change by helping clients address ambivalence. (Hettema, Steele & Miller, 2005). The transtheoretical model of change is a set of common stages and processes of change that were identified from existing theories of therapy (Prochaska & DiClemente, 1998). It emerged concurrently with MI, providing MI with the useful construct of "readiness to change". (Rollnick & Allison, 2004).

MI was mentioned more frequently than any other theme or construct in the entire body of interviews.

"… motivational interviewing, in particular, because it's central to the model, to the intervention. It's all built on that." -Administrator

"I do spend time with motivational interviewing, not only with the clients, but with providers. You know, I see a big component of my work … I use it. I shouldn't say I teach them, but I use my skills in motivational interviewing with them."   -Social Worker

"The intervention is taking MI, motivational interviewing, and using that as a way to develop a partnership with the patient if you will and helping them sort of work towards those health care goals and working through the barriers, working through the systems, but primarily focusing on what's important to them …" -Clinic Care Coordinator

Several MI techniques were referenced multiple times as prevalent in the delivery of the RTC Program. "Client-centered" is a broad term, but in this program it seems to indicate a strong orientation to client needs and authority. The intervention is largely directed by the client.

"You can't really say you should do this, you should do that. It's a lot of letting the client direct and they all do a pretty good job which is probably really different than their interactions with DSHS and their doctors." -Administrator

"Motivational interviewing. And even though it sounds sort of, you know, blasé, you know, with MI, I think it makes a difference in saying to the person, 'is this a good time for you? Would it be alright if we talked about this?' Asking the client's permission." -Administrator

"Motivational interviewing isn't just a methodology but it's a skill that helps people to be patient-centered … They really come at the patient with the idea that, I'm going to meet the patient where the patient's at. Wherever they are in life I'm going to start there with them and in a nonjudgmental kind of way and try and understand from them you know where they, what they need in order to succeed and then, work with their motivation."   -Administrator

Key informants also remarked often about client "readiness", another central concept of the MI approach. An essential part of attention to and regard for client readiness is the practice of "meeting the client where they are".

"… we use motivational interviewing approach which is asking open ended questions and, kind of meeting them where they are, and getting them to articulate the changes that they want to make so that they're more empowered to do that." -Clinic Care Coordinator

"If they aren't ready to engage or choose not to then they don't really participate in the program. They won't really move them on until they are ready to participate; they come back in and we've had a number of people who've done that."   -Administrator

Key informants isolated certain features of communication and the relationship between the professionals and the clients that they make an effort to practice. Trust, listening, persistence, and empowerment were named most. In addition they talked about compassion, praise and recognition, authenticity, caring, and non-judgment.

> *"In the spirit of MI, I think that when patients feel like you are listening to them and that's a lot of, MI is a lot of listening and assessing while you're listening, … when you can relay back to them that you were actively listening by reflecting what you've heard, they feel like, 'wow, somebody is actually listening to me.' That has been huge."*
> *—Clinic Care Coordinator*

> *"Trust. It's essential. You know, really you establish trust with the client and you're building it through this process of multiple, not going to give up on you there, calling and, or, you know, whatever it means that you care …"   -Nurse Care Manager*

> *"We use a lot of MI including verbally … telling them, you know, what a wonderful job they have done. You know, but I mean, the praising, verbally but also in writing, you know, so they can see it, the things that they have accomplished. Especially if they are quit smoking or they, they decrease, you know if they weigh, either gain or loss of weight." -Social Worker*

Elements of the Intervention

Beyond the fundamental framework of the program illustrated above, informants identified a significant number of specific elements and methods used in executing the intervention. Several were mentioned more frequently than the others and seem to be anchors of intervention delivery. These major elements were Care Collaboration, Care Coordination, Meeting Clients' Psychosocial Needs, Providing Resources and Referrals, and Providing a Central Support.

Care Collaboration and Care Coordination. Care collaboration, as described by key informants for this particular program, involves the interaction of a client's nurse care manager or social worker and the client's providers or potential providers, to facilitate getting the client's health or mental health needs met. The function of care coordination is gathering all of a client's providers, including primary care, specialty care, mental health, and chemical dependency, to get them talking to each other and functioning as a team so they do not work at cross purposes, potentially wasting resources or harming the client. There is obviously overlap between the activities of care collaboration and care coordination.

One of the primary functions of care collaboration indicated was independently contacting providers or potential providers to get information, clarification, appointments, or services for clients, continually building relationships with providers in the process.

> *"They're calling the clinics saying, 'Can we try and get so and so into' …"*
> *-Administrator*

"Yeah, and in regards to collaboration, also building relationships with providers. We want to bridge, we want to collaborate. I am part of your team, you know? Don't see me as an outsider. We just want to work together. So making that clear is also very helpful." - Social Worker

Other tasks of care collaboration cited by key informants were providing information, education, and modeling to providers. From their "intense interface" with clients, and access to multiple forms of client records, nurse care managers and social workers provide pertinent information to clients' providers, including factual information and tips about how to individually engage each client. They also educate the providers about the RTC Program, particularly the emphasis on MI. Modeling this technique for the providers is considered by key informants to be a significant component of education.

"So helping them also to understand, you know, about our program but about what has worked effectively with this client in regards to behavior change, and do we, I do spend time with motivational interviewing, not only with the clients, but with providers. You know, I see a big component of my work … I use my skills in motivational interviewing with them … and with the client. And I think we model motivational interviewing."
—Social Worker

A large part of care collaboration is facilitating the clients' relationships with their providers. The care manager accomplishes this through modeling, coaching, advocacy, mediation during conflicts, and basic support.

"… it's scary going into an appointment and they know what they want sometimes when they go into appointments, but they're often intimidated by this person who is, you know, to them, an authority figure, has power over them, and they don't know, a lot of times they shut down because they feel like maybe they're not going to be heard. It feels very relieving for them to have this team, King County Care Partners, supporting them in their health care goals and walking into a room, sitting there saying, you know, and helping just sort of develop that relationships with these providers, with these specialists." – Clinic Care Coordinator

Modeling, coaching, and advocacy were all mentioned multiple times as significant elements of the intervention. Care managers model not just for providers, but for patients, demonstrating self-advocacy and how to navigate and negotiate the system in a way that gets their health care needs met. Coaching them through executing these modeled skills goes along with it, gradually building clients' confidence and self efficacy.

"You know, and I always check it out you know like, before we go into a primary care visit, you know. I'll kind of run down now, these are the things you said were important and I'm just going to be there, you know, and just kind of modeling for them is some of it." -Nurse Care Manager

"That care management, part of it is a coaching role, and helping clients understand how the systems works, how to advocate for themselves in the system, how to be better consumers, I don't really like the term consumer at all, but anyway, you get the point."
-Administrator

Providers also acknowledge the importance and helpfulness of modeling and coaching self-management of one's care in a complex system because it is something they have absolutely no time to do and it is a great benefit to their patients.

"… she now has cancer, and is going to have to need a lot of treatment, and has been helping her kind of navigate the system which has been very helpful." -Physician

Repeated remarks by all types of key informants of the value of nurse care managers accompanying clients to health care appointments illustrates it as one of the most important and powerful roles of care collaboration. In the interface that happens when she accompanies clients to appointments, the nurse care manager can collaborate with the provider as part of a triad that includes the patient, the ultimate authority in the interaction.

"Where I've seen the best results, is where the nurse is bringing the patient to the clinic. Now, by doing that, she's already identified what they're going to talk about, so they've gone through that, and so the patient is aware, so they've already agreed on goals. And then they get the patient here, and then they help the patient feel comfortable in this setting." -Clinic Care Coordinator

Care coordination, as described by key informants, is more of an organizing function. The care manager ideally sets up a solid infrastructure of a health care team for the client, eliminating any barriers to health self-management and health maintenance related to lack of communication between providers, including specialty, mental health, and chemical dependency providers.

"The intervention is communicating with every player in a very complex system and tying together every player in a complex system so that each knows what the other is doing and trying to align care plans." -Administrator

"I've had a client right now who, all his care is at Harborview and I'm certain that the PA that's seeing him at Pike Market, at Pioneer Square, excuse me, is not reading the notes of the psychiatrist that's seeing him in the mental health building, so it's having somebody sort of who knows what's going on in all the different arenas and helps facilitate communication between the different providers and so everybody's all on the same page." —Social Worker

Securing appropriate providers supersedes coordination if the client has unmet primary, specialty, mental health, or chemical dependency needs. In addition the key informants saw meeting clients' basic psychosocial needs by providing referrals and resources as one of the most important functions they perform, freeing the client up to actually work on their self-care goals.

"… they're activated with their goals. They can not achieve it because of the barrier that's there. So what happened in the program that's really great is that as those barriers have been identified, there's more emphasis on housing. Housing has become more available and we're really just seeing people, you know, work to get into a better housing situation and that makes a difference in how they can care for themselves as well." –Nurse Care Manager

Nurse care managers, social workers and clinic care coordinators report they routinely provide resources and referrals that directly help clients achieve their self-care goals, such as weight loss, smoking cessation, support groups, or chemical dependency treatment.

"… so connecting them with community resources, you know, which is part of what my role here is, it's just health education outreach, so making connections with other, and the nurses, you know, give the patients, 'well, have you thought about the pool program at Pike?' Or have you thought about, you know, the cessation program, quitting smoking program here?" -Clinic Care Coordinator

Health Education. Health education was mentioned as another key element of the care management intervention. This teaching, done by the nurse care manager, provides the client with the skills or techniques, and concrete tools to self-manage their medical conditions. For example, a diabetic client might be taught the "skill" of measuring blood sugar, and given the tool of a "glucometer" to do this on a regular basis.

"Well that's what I think this whole program has done. I mean, by having the nurses, by having the nurses actually give them the techniques." - Clinic Care Coordinator

"We try as much as we can to give clients tools. I'm a strong, strong believer in tools and so we have these protocols that we wrote as I said for the standards of care. And that we try and give clients tools that they can use for their health and that includes glucometers, pedometers. It's not just good enough to say, 'Well you really should do this', if they don't have the tools to do that." -Administrator

Central Support. Key informants of all roles talked about the provision of a central, organizing support for the client in the nurse care manager, as a core essential ingredient of the intervention, described as a "go-to" by one interviewee.

"I think patients like having someone who's sort of a go-to … just having a person that's their go-to that can help them." -Clinic Care Coordinator

"There's someone out there organizing this person who is otherwise is in, just in chaos." -Physician

They qualified this central support with the particular quality and frequency of the contact between the nurse care manager and client. This was routinely referred to as the "intense interface". Key informants contrasted the RTC care management interface with other case management programs by the holistic approach of RTC, meaning it is not disease-specific.

"I think the intervention is more of a direct, intense, interface with the client that they would otherwise get in any other program." - Administrator

"I would assert that 1-800 nurse at the other end of the line, chronic care management that typically is disease specific doesn't work, as a matter of fact, that's why the state put out the RFP in the first place, they did that 7, 8 years ago. They evaluated it. It didn't work. They spent a lot of money. And that kind of care management in this population is worthless, so you really need, you need the face to face contact, and you need the intensive care management." -Administrator

Another element described as a component of the "intense interface" was frequent "monitoring" and "follow-up", or regularly checking in with clients to mutually evaluate progress on their self-care goals and any needs they might have in supporting continued progress.

"I think too, having the time to do those follow-up calls. That's a piece of it. To stay in contact and engaged."   - Nurse Care Manager

"I think the regular contact with the clinical team which they have a tracking mechanism to make sure they're in contact with people. That helps retain them." -Administrator

"I think the regular calls. The regular check-ins, definitely are a big piece in keeping somebody engaged."   –Social Worker

Clients also have the opportunity to initiate contact with the nurse care managers and social workers as they form a working partnership. Clients are nurtured through unlimited access to support, which many of them take advantage of, contacting ADS staff frequently.

"Many of them are going through these treatments with no one but this nurse. Think about what it means in their life, the process they're going through because they're calling their nurse at three in the morning to leave her messages. They're calling their nurse, some of them, three and four times a day, let alone a week … so I think that that's a very core piece for the client in terms of the process is that there is a provider there beside them." -Nurse Care Manager

Two nurse care managers described the intensity of the interface as "walking with the client", and remarked on how valuable it has been in understanding the health care system from the client's perspective.

"I think we have a unique perspective that we've been able to walk through systems and by walking through the systems with the clients we've identified a lot of barriers." –Nurse Care Manager

"I just would have never believed what people had been going through, and I've been a provider thirty years you know! It's like… remarkable … people sometimes think we're a client and so we really get a great perspective." –Nurse Care Manager

In addition to the intense central support, clinic care coordinators pointed out that patients have "multiple contacts" if the nurse care manager is not available. In addition to the ADS social workers, clinic care coordinators are brought in early in the process and clients have access to them as well.

"Yeah they have multiple contacts. If this person isn't available, then I'm available in the clinic for them and then I'm constantly communicating with the nurse. So, I mean, just that availability is very comforting for them. I think we're a little more available than somebody else might be. And the level of intensity in which we work with them is huge too." -Clinic Care Coordinator

Most Powerful Components of the Intervention

During the interview key informants were asked specifically what features of the program are *most* helpful for clients, or deliver the most powerful impact. They came up with many unique answers and five overall groups of what they believe to be the most effective components of the RTC intervention. Interface with providers, professional roles of nurse care manager and social worker, meeting basic needs, MI, and the client interface with the nurse care manager were the categories of the most helpful pieces of the intervention.

Interface with Providers. The interface with providers included 1- collaboration with the clients' providers, 2- providing an "extra set of eyes" on the client, 3- facilitating communication between clients and providers, 4- having someone who sees the big picture of clients' health care, and 5- bringing the client to the clinic.

"The biggest impact is making sure all of the medical professionals that are dealing with a client are in communication, that they all know what's going on. I know that's a huge thing and you know ideally we would have one sort of system that can help with that, but you know we're way far away from that, so having a King County Care Partners nurse or social worker kind of be that link I think is great and that's a huge positive for this program 'cause not only does it help the individual client in their own care but it starts to connect and make the system as a whole communicate better." -Administrator

"… extra set of eyes. I know that ____ is working with a client right now who accidently, question mark, intentionally, question mark, set himself on fire. And, in what may or may not have been a suicide attempt, and he's got depression and schizoaffective disorder and he has recently relapsed on alcohol and yet there was a practitioner who was gonna start interferon therapy for him for hepatitis C and so she's like, Ack! He shouldn't even be a candidate. Ever." –Social Worker

Professional Roles: Nurse Care Manager and Social Worker. The specific professional roles of nurse care manager and social worker were both mentioned as crucial for the intervention,

as well as the multidisciplinary approach. Skilled nursing and health education were part of the professional nursing role seen as the anchor of the intervention.

> *"I believe having a nurse work with them. We are trying to have every client that is willing and open to accept the information about the standards of care for their particular disease process, so that they're able to sit down with the nurse and let's say they have diabetes. Within the 12 month period, if they're willing and able to listen, the nurse will go through all of the aspects of diabetic care including the importance of foot care, eye exam, dental care and really breaking it down in pieces."* -Administrator

> *"The critical component of having the social worker and the nurse, and I can give you many examples. A client with diabetes or a client who is having chemotherapy but they are homeless. How can they manage their diabetes? How can they manage their symptoms of, you know, cancer treatment, if they don't have a home? So the importance that the nurse is doing with the medical teaching, but then and also for me to work on housing and how these two things play an excellent role in the outcome of the these client, of managing their health condition."* —Social Worker

Meeting Basic Needs. The ability to help clients meet their basic needs as one of the most powerful pieces of the intervention was touched on in several ways including managing clients' social complexity, giving clients the opportunity for self-actualization, and providing fast-track access to social services.

> *"If I were to go into SHA or King County Housing Authority today, I couldn't get a Section 8 voucher. They don't have, their wait lists are closed, but because we're a special program that we have access to resources that, or we get to go to the head of the line, you know?"* -Social Worker

Motivational Interviewing. MI and some features of this approach, such as being client centered, following client authority, facilitating client self-efficacy, assessing of client needs, and encouraging client self-worth were isolated as some of the most helpful aspects of the program.

> *"I think it works best when the program really helps give voice to the clients' needs and ideally at the end of the day, you know, when the patient graduates they're able to give voice to their needs and we've succeeded then in some way, but I think across the board, it's when, and there's a lot to that, 'cause you gotta figure out what is the need. I think the greatest strength is in the ability is to discern those needs and give voice to them and then get them met."* -Administrator

Key informants who had received training in MI through the program were asked specifically how it impacts their work with clients. They felt it helps them and their clients focus, get to the core of a problem, and actively problem solve.

> *"It helps to staff that person on just an MI approach getting right to the core of their problem."* -Nurse Care Manager

"So it's, you know, it helps us focus with our clients … provides the channel for the, you know, the path from which to walk through. So, and that makes it so much easier rather than trying to muddle through." -Clinic Care Coordinator

You know, so it's just this problem solving, just all the little things that are keeping him from doing what he needs to do." -Social Worker

Key informants also communicated that MI helps them focus on the client's agenda, where the client is most motivated and most likely to make progress.

"So then the client can then come within themselves and see what it is they're willing to work on." -Nurse Care Manager

"It helps us to know what their agenda is. Our agenda might not be their agenda, and so when you're using MI and you're actively listening, a lot times, without even talking, you can find out what's important to them, and so, through that, I'm able to know where to go with them. I'm not going to spin my wheels working with them here because it's not important to them. They just said, X, Y, and Z is important to them so instead I'll put my energy working there." -Clinic Care Coordinator

MI was also mentioned as a tool for rapport building with both clients and client providers.

"Yeah, and in regards to collaboration, also building relationships with providers." -Social Worker

"I use more of the validating and the trust and the, those kinds of tools that build rapport." -Nurse Care Manager

Client Interface with Nurse Care Manager. Qualities of the relationship between the nurse care managers and clients, such as accessibility, frequent in-depth contact, and the "one on one' nature of the intervention were presented as instrumental to the success of the intervention. Clinic providers also offered the way they thought the interface between the program and clients is one of the most helpful elements of the intervention. More than one illustrated the relationship as one of clients having someone to look out for them in a difficult world.

"Just having a resource, having someone there they can talk to whether it's me or one of the nurses as a liaison and somebody who's advocating for their health and a lot of these clients feel like, you know, nobody cares about them. I mean I've gotten calls where they'll be like, 'thank you so much for sending that letter', and it's, to me, it's just a follow up letter and, but it makes a big difference to them." –Clinic Care Coordinator

"It's the social, the sense that someone's looking out for them in a hard world." -Physician

Impact of the Intervention – Benefits

Health Self Management. There are many perceived benefits and very few negative consequences of the RTC Program for both the individual clients and the county health care system as a whole. Health self-management was the most frequently cited benefit for clients.

> *"'It's amazing the amount of education that I got from you. I'm doing better with my diabetes.' While he was in the program, he lost 60 pounds and he's very engaged with his mental health provider, with his psychiatrist, and he knows when he's not doing well, and he knows what steps he needs to take to prevent relapses. I mean, this is what they have shared." – Social Worker*

Gaining the confidence and self-advocacy skills were seen as vital to achieving this self-management. Other benefits mentioned were health, maintenance, improved health, self-efficacy, and self-actualization.

> *"Yeah, giving them the knowledge and education around whatever chronic disease condition or mental health condition they have so they can improve their own self-regulation and self-monitoring … so that they can just keep improving their self-monitoring and self-confidence." -Clinic Care Coordinator*

> *"And pretty much when the visits that I have participated in with clients, pretty much they take the lead. They do the talking. I just kind of like step back, you know, because they are activated and that's, that's just a wondering thing to see. You know, that this is your thing and you're going to be your own advocate." –Social Worker*

Individual Benefits. Key informants illustrated the individual benefits for particular clients by recounting success stories. Others mentioned that they are inspired by the stories they hear in meetings.

> *"… we see benefits all the time. I can tell you about individual upon individual stories that are amazing stories and so clients, I know, I have no doubt, clients benefit individually." - Administrator*

> *"Unbelievable, the stories that I hear in our meetings … they've saved a lot of lives and there've been people who have suffered terribly in their lives and suffered from posttraumatic stress syndrome that they've been able to bring out of their shell. You know they've been kind of reconnected back to the community. They've gotten the attention they needed. So many people don't, even though they're in the high utilizer group, they're not getting the right care." -Administrator*

Most Likely to Succeed. Key informants were specifically asked if they could identify any characteristics of clients who are more likely to improve or be successful in the RTC Program. They identified broad areas of client attitude, mental health, severity of medical illness, and psychosocial stability. Many of the key informants also explained why they thought it was difficult to isolate characteristics. The most frequently mentioned success characteristic was a client attitude of motivation, desire, and willingness.

"I think that question speaks to how motivated a patient is and how important the health care goals that they've set are to them." —Clinic Care Coordinator

"I think that it depends on what's happening at the time when we call them. Many of them might be in crisis and they say, 'This is my time to change, this is my time I want to do something about it.'" -Social Worker

"The people that I think have had done the best are those that really and truly despite all the wounds and battle scars, they have a desire to get better." -Administrator

The next most popular characteristics key informants discussed had to do with severity of medical and mental illness, and chemical dependency. Absence of or less mental illness, chemical dependency, and cognitive impairment were clearly seen to indicate a greater chance of engaging in the program successfully.

"Well, with the ones I've worked with who don't have more severe mental illnesses I find that they're, well they're more accessible to me to work with."
—Clinic Care Coordinator

"This lady that's talking about the child that she's pregnant with and she's obviously not pregnant, and she's off in this other place in the world and can't be re-directed back to reality." —Nurse Care Manager

"I think if you get some clients that aren't, you know, extremely cognitively impaired."
—Nurse Care Manager

Less severe health problems, illness for shorter periods of time, or having only health problems were illustrated as predictors of success.

"There's a certain stage that you really can I think, have a lot more impact on the client. And, you know, if they're end stage, you know, with liver failure and various encephalopathies, and you know, different things, it just doesn't seem, you may be able to do something, but it's not as effective." -Nurse Care Manager

"The medical complexity without the addiction and such, I think those folks tend to do good." -Physician

"Older clients before they transitioned to Medicare. And my goodness, they could really get, achieve well. They just needed somebody in there to help them access resources … They just didn't know, they didn't have access, they didn't have confidence, you know, they're older, look to the authority of the provider." -Nurse Care Manager

Several key informants mentioned that if clients have a "social structure" and housing they are better able to navigate the program.

"One woman with very bad chemical dependency, cocaine abuse, still an issue. She's been through treatment twice. She's really trying and never been through inpatient treatment. She's like sixty years old. She's really trying hard. She's got a place to live. She's got a mother who cares about her, I don't think she'd be trying and trying again and she's been in the ER much less than she had been previously." -Administrator

Finally, multiple key informants, particularly those who work directly with the clients pointed out that it is hard to predict success in the program when there is no specific measure for it. Others thought there truly were not any characteristics that predicted success. It depends on the individual client.

"So I think it is really individual and unique to people and also it would also depend on which measure we've decided to use with them. Because for some people, they may still be deep in chemical dependency but it's the first time that they've really considered it or seen themselves as an alcoholic even." —Nurse Care Managers

"I mean, for me anyways, you know, they have goals but it just seems like they are not very engaged and just kind of, you know, they're kind of on the border. But I've been finding that some of these people, like the relationship building, at some point they do become impactable. So I can't really give a characteristic right off the board." —Nurse Care Manager

System Benefits. Cost benefits and system development were the two main themes isolated as advantages of the RTC Program for the health care system and the county. Cost benefits mentioned were decrease in crime, decrease in inpatient hospital stays, harm reduction, prevention of more serious illness, and decrease in mortality. Key informants referenced decrease in emergency department utilization most often as a cost benefit for the system.

"… what we have also helps the system and all of us, as taxpayers, has been with big numbers. I mean I can give you one example of a client that was going to Harborview every week with crack cocaine use. You know, what are the symptoms of crack cocaine? You know? Increased heart rate, you know, a lot of hallucinations, delusions. I mean, medically, the client has diabetes. She was going to the ER, she was there not because she wasn't managing her diabetes or because of her heart condition. She was going there because of her crack cocaine and she was there every week, you know? Since we, our intervention, she's been to the ER, how many times? I think about five from September (09/09) to now (4/10)." -Social Worker

An added benefit of all the work the care managers do to coordinate clients' care is that the healthcare system is adapting at the same time because of the multiple collaborative efforts of the RTC Program on behalf of individuals.

"You can just feel that it's different, the system building that's happening across the county with the community clinics and with Harborview and the effect the nurses and social workers are making with individuals clients and doctors in clinics. It's very exciting." -Administrator

"… part of also the piece of this is not only the direct care management and the work that's going one on one, but it's the system. Every Friday we sit at a table, the community clinics and Harborview and the nurses and you talk about systems and what you can do to improve it and the work that's been done over the last few years has been amazing and it's where health care needs to go forward. You have to have all these people talking to each other, especially in a region … I see it as an important piece for building the healthcare system especially the safety net system in King County." – Administrator

Impact of the Intervention - Negative Consequences

Cost Increase, Responsibility. Several negative consequences of the program were brought up occasionally. One nurse care manager pointed out that as clients get more attention and care through the program, they may discover previously neglected medical problems. These medical problems are potentially expensive, thereby running the risk of increasing costs rather than reducing them. Several key informants also mentioned that clients might perceive all the extra attention and coordination of providers as intrusive, as well as forcing them to take a level of responsibility for their health they do not necessarily want.

Dependence. One concerning negative consequence to individual clients that key informants introduced multiple times was a dependency fostered by the intensive interface between the client and nurse care manager or social worker. Nurse care managers, social workers, and clinic care coordinators all explained that clients sometimes build a reliance and emotional attachment that is difficult to sever.

"I sometimes wonder how deep this process is for a client. You know, they're very scared some of them when they have to go off the program." –Nurse Care Manager

"I'm starting to see that some of them do become kind of dependent. You know, they really like having this person that they can call and get information from, resources, you know. You're the only one that's helped me over the last 20 years and they really see that as a lifeline. And you know, the sad thing is we're not there for them for the long term, you know." –Nurse Care Manager

"Patients are not always able to emotionally just detach and feel like they're not just being shuffled off again." –Clinic Care Coordinator

Physician Conceptualization of the Intervention and Its Impact

Overall, physicians described the intervention and impact of the program on their patients and themselves almost exclusively positively, but somewhat differently than the rest of the key informants, suggesting that they need more support and education around the RTC Program. In contrast, the clinic care coordinators, who work in the clinics with the physicians, described the intervention and its impact in the same manner and with the same depth of understanding as the rest of the key informants.

Getting Patients to Appointments. The benefit the physicians mentioned most, with great relief and enthusiasm, was "getting the patients to appointments". They value the actual organization of the care manager to get them physically there, as well as the extra information about their patients provided at the appointment, and the benefit of attention to and management of clients' complex social issues.

> *"… it's just patients who, you know, had a long history of not showing up for appointments, not getting their labs drawn, not attending to this stuff and then when the nurse care manager is with them, they do."* -Physician

> *"… when the case manager comes to the appointments, it's very helpful. 'Cause it's like you have more continuity from the other places they've gone or we actually get information."* -Physician

> *"Getting them to appointments and helping to consider and manage their illnesses within a complex social situation. As physicians we touch on that but we've got, you know, we don't have tons of time unfortunately with any given patient. We can help to manage some things but in patients where the social complexity is to the extent that we can't manage it's nice to have someone else help to manage that."* -Physician

Case Management. All the physician key informants called the core of the RTC intervention "case management", in contrast to all other key informants who uniformly identified it as "care management". Although case management and care management sound similar and are often used interchangeably, there are some fundamental differences. The main goal of case management is to link or coordinate activities in a system to provide the client with a comprehensive plan of care. Care management, on the other hand is a "strengths-based model of consumer-driven care". Beyond a skill set it is a philosophical approach that emphasizes the relationship between the client system and care manager, and maximize client self-determination and involvement. (Morano & Morano, 2006). It is unclear whether the key informant physicians have any knowledge of this distinction, but it seems unlikely that this is completely a coincidence that they conceptualize the RTC Program as *case* management.

Patients as Passive Recipients. Physicians often portrayed the client as a passive recipient of services. They mentioned things that distinctly did not include any sort of client self-determination or active involvement. One physician who admittedly did not know much about the program, and was having a hard time distinguishing it from other programs with which she interfaces, thought it was most helpful for cognitively impaired clients, so the care manager could take responsibility for what the client didn't understand or have the capacity to act on. She also mentioned the benefit of her patients "not needing to be proactive", as the care manager initiates communication with them. Two other physicians mentioned one of the main benefits of the program being the "medication management" the clients get. All of them mentioned the improvement of their patients' health management, but in the passive voice, as "better managed health", in contrast to other key informants' descriptions of "self-management".

CHANGES

There have been multiple changes to the RTC Program since its inception, as the result of experience and insight. They are almost exclusively viewed as beneficial by the key informants. The following were identified.

Expanded Timeframe for Program

Over the trajectory of the program, the length of time for the client to complete it and graduate, or as it is now referred to, transition, has expanded. Initially, before the RTC iteration of the program in February 2009, only six months were allotted for clients to complete the program, but key informants explained that was an inadequate amount of time to engage this population, address their needs, coordinate their care, and teach them the self-management skills needed to successfully transition them to their medical homes. Now there is a "soft goal" of twelve months for clients to transition, recognizing that some will take less time and some a little more depending on individual circumstances.

> *"They also only gave us six months to work with them and I had concerns that we were actually doing more harm than good doing six months with this clientele because many of them have huge trust issues. And so there's a great deal that goes into just- it's about relationship building is what a lot of it is, and building that trust, and so it was like when we had six months, I felt like we were, we had just got the trust built and just started some engagement and then it was like we were dropping them on their heads. And so now we get up to a year to work with them." -Nurse Care Manager*

> *"Now there's no formal limit on the amount of time, but I think I would say that there's sort of a soft goal that you know that this would for the average client might play out over a twelve month period, so, some shorter, some more, so when somebody's achieved their goals you know and appears to be able to function pretty well within the system …"   -Administrator*

Assessment Changes

Several changes have been made to the assessment over time, including increasing length of time to complete the assessment, addition of instruments such as the SF-8 and Patient Activation Measure (PAM), and addition of a post-assessment.

The time to complete the assessment was relaxed because having one visit or sitting to complete the lengthy assessment and one clinic visit is not realistic with this medically and psychosocially complex patient population.

> *"I think the biggest change is going from the feeling of having to get it all done at one sitting to it's ok to spread it out over time because it's just realistically - a lot of the clients, especially if they're using or if they have real mental health issues, they can't sit with you and answer questions for more than x amount of time. I think that's the biggest change. From a nurse point of view feeling like they now have flexibility which I think is a good thing."   -Administrator*

"What we've morphed it into which is great - when the social worker starts the engagement she tries to get as many questions out of the way, you know where do you live, maybe some domestic violence questions, or whatever, diagnosis if you know it. She'll also do a lot of research in to the medical records to see what's out there - what is the current diagnosis, medications, she'll get that in and then confirm it with the client, so that's sort of a pre-assessment then the nurse will meet with the client wherever they can and just start the assessment as well. They may not finish it. They may not even get it started but at least you have a contact, face to face - this is who I am, this is what we're going to try to do over the next year." -Administrator

Assessing Improvement. Administrators, nurse care managers, and social workers were asked how client improvement is assessed. Formal assessment tools in an initial assessment and a post-assessment, such as the Patient Activation Measure (PAM) and PHQ-9 were mentioned along with multiple clinical evaluation markers such as progress on self-care goals.

"We have pre and post test assessments, so for instance we look at PHQ9 scores at baseline and when they transition and then we also look at the goals that they've accomplished." -Administrator

The most frequently cited indicators of improvement, gleaned through "clinical evaluation", were demonstrations of progress through the stages of change, and progress on self-care goals.

"Stages of change. I mean that's… watching them, you know, progress through stages of change." -Nurse Care Manager

"I think it's looking at the person and saying they actually met or worked on elements of self care goals. They may be small incremental goals where someone may have gone as far as joining the YMCA. Someone may have lost weight. Someone may have gone from pre-contemplation to contemplation about attending a smoking cessation class. So it's very involved but I, we try to celebrate each win, each positive forward step. And most often every person makes some sort of change." -Administrator

Additional indicators through clinical evaluation offered were client readiness, self-management, stabilization, maintenance, satisfaction and confidence. There were also several mentions of methods through which clinicians get information to make assessments on improvement, such as client records through various databases such as those of their medical home, and also client self report.

"Part of it is a clinical evaluation that looks at a client as a whole and so as I say in the most straightforward case, the client has some condition or conditions that they're now able to manage. We've identified resources they need and whatever resources they need that we can find for them, we've done that. There's some confidence and readiness on the part of the client to step away in a sense … when I have the discussions about patients who are graduating, the nurses, they're very good. They can say, we don't capture it formally, but they can, they're good at articulating why they think somebody's ready." -Administrator

One of the key informants talked about a need to develop more standardized criteria for clinical assessment.

> "I think it would help us to have, you know, somewhat more, better articulated, standardized, objective criteria that we can sort of go through to say, like a checklist, where yes, no. We don't have that and I think right now we're probably a bit too much gestalt." -Administrator

Patient Activation Measure (PAM). Key informants were asked their opinion about the utility of the PAM, particularly if it helps in engaging clients in the program. Most respondents voiced that they thought it is "worth a try" although it has some challenges. Several clinicians responded clearly that they find it a helpful tool that they actively use for client assessment and engagement.

> "It's helpful to know where the client is … and they don't only give me the word like 'strongly agree', right, or whatever. Sometimes they will build on telling me their experience with providers. So that's, to me, that's very helpful to me and I think it's helpful. —Social Worker

> "There are folks that just want to just say 'yes' or 'no' and there are folks who say, 'Well, no I don't know what the cures for my disease are, or the treatment for my diseases are and that really pisses me off.' So you're right, there is some useful information that can be gleaned." -Social Worker

One key informant thought the PAM worked well with MI but another expressed that when using MI, there really is no need for the PAM.

> "Using motivational interviewing and addressing the PAM instrument is that for the clients that may want to say, you know, 'I'm a victim of whatever, I'm a victim of the program', that being able to say at the end of the day, you're really the person that is calling the shots. You're the individual that's making the choices about whether you take that medication. For some clients I think that it's direct and it may be the first time that they really thought about the fact that maybe they are responsible for decisions they make and they really can't blame someone else." -Administrator

> "I mean, using MI, I think that, you know, we ask the pertinent question and I just see the PAM as being, not a terribly, you know, unique." -Nurse Care Manager

Others remarked that they thought the PAM is probably useful, but they were not sure if it was more useful than clinical evaluation. The question of what is being measured with the tool was also a point of concern.

> "Does it provide any information above and beyond that which a good clinical nurse doing these other things in terms of assessing the patient would be able to ascertain?" -Administrator

"There are things that just can not be measured by a number. So maybe the client stays at the same level on a PAM score but they actually started pursing some sort of detox program. They've actually moved. They moved from a very toxic building or drug infected building to … with a Section 8 voucher. They still may say the same on the PAM but the circumstances are different and overall their health may be better."
 -Administrator

Finally, key informants expressed that the PAM is very difficult with certain clients, particularly the cognitively impaired and non-English speakers.

"It's very difficult to complete the PAM with the, well, cognitively impaired, number one, and then certain cultures have difficulty understanding it and then when you're using an interpreter, you're not really sure if it's being interpreted correctly and so a lot of times you either get, 'I don't know what you're talking about, you're crazy.', 'Why are you asking me these kinds of questions?', or, 'Why are you saying these things to me?', kind of responses from both the interpreter and the client where they just simply, just can't answer. Just don't understand it at all." -Nurse Care Manager

Immediate Involvement of Clinic Care Coordinators

At the start of the program a client worked with the nurse care manager until they were ready to transition to the medical home. At that time the nurse care manager would transfer the client to the clinic care coordinator at the client's primary care clinic. Because the client had typically never met or interfaced with the coordinator, the shift could be rocky, risking progress the client had made. This was mitigated by weaving the clinic care coordinators in to the client's care as they start the program.

"We try to pull the care coordinators earlier in the process so they're working as a team the all the way through and there isn't a disjointed handoff at the end of the care management."   -Administrator

"I would come in during this transition period and work with them during that time only and now it's more of a working with them from the beginning all the way until they're transitioned to standard clinic care." -Clinic Care Coordinator

Multidisciplinary Team and In-house Outreach

Originally KCCP contracted with Senior Services to have their Information and Assistance (I&A) team engage clients. Key informants explained that because they did not necessarily know the RTC Program population, were not part of administering the program, and did not have the advantage of walking across the hall to collaborate with ADS staff, they were not ideal to engage clients. Now two social workers, one of whom is a Chemical Dependency Professional (CDP), perform the initial outreach and engagement, completing some of the assessment in the process.

"The program has started and changed, currently we have the social workers that are engaging the clients. I think maybe ___ is doing most of it. She's a CDP and she has a

great deal of experience with this particular population in a number of different settings." -Administrator

"I think by pulling it in house, having it reside with a person who has much more tangible experience with working with this population on the street so to speak, I think she is just able to engage these people in ways that you know I think our engagement rate is now near sixty percent which is amazing." — Administrator

"I think since we've added a multidisciplinary team, that's been a huge help."
-Nurse Care Manager

Eligibility Changes
With experience the RTC Program expanded the population eligible to participate. Initially they worked with "community-based" clients, then eventually added residents of nursing homes, adult family homes and developmentally disabled (DDD) homes. Due to issues that became apparent over time, such as professional territory, and various mental and physical deficits that prevented client participation, these groups are no longer eligible for participation.

"We at one period of time were receiving people who were in nursing homes, adult family homes and DDD homes and it's not appropriate for them to be in this group so we aren't receiving them anymore. They can't really benefit from this. And people who are cognitively not able to set self-care goals. It doesn't really work for them."
-Administrator

Increased Focus on Mental Health & Chemical Dependency
Key informants voiced that over time they have attended more to mental illness and chemical dependency, focusing on addressing these health issues so clients can more successfully navigate the RTC Program.

"We went from the beginning of the project was more on just diseases, clients had lots of the different diseases, where the change then was to more clients who had lots of diseases plus mental health issues plus chemical dependency, so the focus had to change on the clients and what was being, you know, the specific interventions for each client, the focus changed to more looking for treatment and working with the mental health system. We've had those clients before, but it just kind of fell out that way, but when the focus changed in February '09 to specifically looking at those extra pieces I think." -Administrator

Motivational Interviewing Skill Building
Increased training and skill-building in MI was seen as a beneficial change that has helped nurse care managers, social workers, and other clinicians, deliver the program more effectively.

"Now how things have changed, I think having the motivational interviewing piece and having that specific training I think has helped the team, whether it's the nurses or the clinic coordinators, it has helped them in their own practice and their own interventions with the clients. That hasn't changed the global intervention that's King County Care

Partners, but I think it's changed the one on one interactions, not only with engagement and getting the clients to consent and wanting to be part of it but also the ongoing practice that the nurses and social workers have with each client. I think that's a big change from the beginning. We didn't have that. I mean we knew about motivational interviewing and some had some experience and we had some trainings but with the grant or the Center for Health Care Strategies (CHCS) funded project over this past year, I think that's really helped." -Administrator

Key informants who received the training were asked specifically about their experience of the program's MI training. Four informants said they had received training in MI as part of the program. The remaining participants had received some sort of training in MI but not with the program. Key informants expressed appreciation not only for the formal trainings but regular ongoing skill building activities.

"We had a training … we had Chris Dunn and was it last year? It was pretty, pretty profound. You know, it really gave me a strong foundation for understanding."
-Nurse Care Manager

"The skill building in particular has been awesome for me 'cause it's a one-on-one thing where I can develop my skills even more. But yeah, so MI, while it's not new to me, it's still been very helpful, especially the skill building part where I can do one-on-one case staffing and maybe just get some, a different perspective or some pointers."
–Clinic Care Coordinator

"You know that last speaker we had was fabulous and he was somebody local. It was really good … it was very real world, so I prefer the speakers that come in that are actually using it rather than the people that are the trainers 'cause they actually give us better examples and give us better or clearer opportunities on how motivational interviewing can be used, or, what, you know, doesn't work too."
–Clinic Care Coordinator

CHALLENGES

Key informants identified four major types of challenges: programmatic challenges, challenges to client participation, challenges with partner clinics, and wider systems challenges.

Programmatic Challenges
Data System. Key informants talked about the problematic data system repeatedly. Challenges with the data system seem to spill over in to every aspect and function of the RTC Program with negative consequences.

"An ongoing issue is our information system. We started out gangbusters with _____ … but then there were personnel changes and things got stalled and not only did they get stalled but they sort of went backwards and that's a huge challenge right now. It's not easy for us to input data. It's not easy for us to get data out." -Administrator

"… we've had quite a few technical difficulties with changes in the system. So we've had things, even, I think it was a year ago in spring, where actually data disappeared entirely from the system, our assessments and various things. I think that they did get, succeed in getting, most of those back. I think was a year ago in spring, so then there is the catch up aspect sometimes on the data itself."   -Nurse Care Manager

Cross-Institutional Information Sharing. Related to the data system difficulties are challenges actually sharing information cross-institutionally. HIPAA prohibits exchanging information about shared clients that by email, making communication between nurse care managers, social workers, and clinic providers complicated and time consuming.

"… the communication that goes on between all of us is very helpful. I just feel bad because I think that's a weak link, because we have to work really hard at doing that communication … like, if ____ or ____ or any of the nurses, you know, so we can't communicate by e-mail … cause you can't - patient confidentiality … it makes a big difference because the nurses are having to call us and we're not here or if we have to call them and they're not there. "   –Clinic Care Coordinator

Caseload. Rivaling the importance of data system challenges was the sizeable caseloads of the nurse care managers and social workers. All key informant roles, not solely the effected nurse care managers and social workers, put forth the caseloads as a challenge in properly administering the program.

"… there's just not enough of a care manager to go around. They manage. You have seen what some of these clients look like clinically and their caseloads now are over 60."
–Administrator

"… I mean the RNs are just slammed. The case managers are just slammed."
–Clinic Care Coordinators

"Did we say reduce the caseload? Can I say that again?" -Nurse Care Manager

Work Flow. Nurse care managers and social workers voiced concern that the inconsistent work flow and lack of a weekly schedule or structure further exacerbates the caseload burden. Nurse care managers described the erratic distribution of clients, resulting in receiving large numbers of clients all at once.

"They've got to figure out some way to even out because it's like the tides going in and out. You know, you're transitioning, you're getting new clients in, you're trying to manage the ones, they've got to figure out the work flow here …there was one week like what were I got 40 new clients in one week. I'd have to tell you, that was like, I'm a hard worker and I'm really good at multi-tasking and, you know, being remarkably efficient but that was overload …" -Nurse Care Manager

"It is like feast and famine … there's definitely like a front loading. So I don't know if, if we could get, you know, half the names on the 1st and half the names on the 15th or something. That would spread it out a little bit more." - Social Worker

"Because you get a group like that, a large group like that and you're told you need to make contact with all those people in two weeks and get home visits scheduled in a month. It's impossible." –Nurse Care Manager

Work Structure. With regard to structure of the work week the nurse care managers and social workers find that lack of any consistent structure makes them much less productive than they could potentially be.

"… it does it make it easier for me to do my job to not have meetings every day. To kind of divide, to have, you know, an awareness of open days for these visits. Something like that, and so I've been working to ask to have meeting days kind of the same as my paper days so that we have sort of an organized …" -Nurse Care Manager

Client Visits in Community. The nurse care managers and social workers also painted a picture of the challenges they face with regard to client visits. They pointed out that the job requires them to move quickly between distant locations, mostly to which they have never been, all over King County.

"You can drive up to eighty, a hundred miles a day between visits or even for one you might have a visit out in Pacific, right out on the edge of county somewhere." -Nurse Care Manager

In addition, they explained that much attention is needed to insure safety in the unknown situations they encounter out in the community.

"You have to be extremely open and flexible, and aware of safety, high awareness to safety, and you do need to ask those questions ahead of time, so there's all these little nuances, you know, like, Do you have pets? Do you have any weapons?" –Nurse Care Manager

Other programmatic challenges mentioned primarily by nurse care managers and social workers were agency bureaucracy that prevents them from getting tools they need in a timely manner, and lack of clerical support, leaving them responsible for it, which they feel is cost-ineffective and a poor use of their skills.

Staff Turnover. Turnover of ADS staff was mentioned as a difficult hurdle that the program weathered when one of the nurse care managers was replaced.

"You know if you have staff turnover, right now we have a dynamite team but whenever we have staff turnover it's really hard to bring somebody on because it takes three months in order for somebody to absorb a case load because they are so complex." -Administrator

Measurement. ADS staff and administrators explained that the formal measurement tools are not always effective in getting a gauge on the most important client improvements or accurately measuring clients' progress.

> *"A percentage that there are things that just can not be measured by a number. So maybe the client stays at the same level on a PAM score but they actually started some sort of detox program. They've actually moved. They moved from a very toxic building or drug infected building to …with a Section 8 voucher. They still may say the same on the PAM but the circumstances are different and overall their health may be better."*
> *-Administrator*

Challenges to Participation

Key informants introduced a whole family of challenges that are essentially barriers to clients' recruitment and optimal participation in the RTC Program. The most frequently mentioned challenge of this type was unmet basic needs, with an emphasis on housing. Obstacles in contacting clients, working with chemical dependency and mental illness, and language and culture were also seen as substantial challenges.

Basic Needs. Many of the potential RTC Program clients are not only low income, but according to key informants, do not have their most basic needs met, making it difficult for them to reasonably engage in a program that demands active client participation. Key informants routinely used the term, "Maslow's hierarchy", to capture the barrier posed by unfulfilled basic needs.

> *"Maslow's hierarchy. Food, shelter, definitely comes in to play." -Administrator*

> *"Yeah, the usual barriers like transportation, housing is another one, just all those things at the bottom of Maslow's hierarchy." -Clinic Care Coordinator*

Homelessness or unstable housing was mentioned most frequently as a challenge to clients' participation in the program.

> *"Lot of couch surfing so, you know, I got one, like, older lady that, you know I mean, she's been kicked to the curb, you know, and all the kids' houses and it's really hard to keep up with her." -Nurse Care Manager*

> *"You can't even take care of their health needs because they do not have housing, maybe, you know there might be other problems that are preventing them from doing that." –Nurse Care Manager*

Contacting Clients. Homelessness and unstable housing, including shelter placement, make it difficult, among other things, for the nurse care managers or social workers to contact clients.

> *"And just an image of our clients, sometimes, in particular these kinds of homeless situations, I have this image of King County and I have a fly-fishing pole. Trying to get them on the line, particularly when they're wandering around the county, you get these*

calls and they are just all over the place, you know, and you see them, they're over there in Maple Valley and now they're over here in Harborview and now they're over out in… you know, where… Kent or Renton, or-." -Nurse Care Manager

"Then there's the ones that are really hard to get. Because you know maybe they're in a shelter situation where they don't have a phone so you're leaving messages for their case manager and it can go on for weeks to try to get a hold of them." -Administrator

Contact difficulties go beyond lack of stable housing; client barriers related to the telephone were thought to be a difficult barrier to communicating with clients on a regular basis. Chaotic lifestyle, itinerancy based on admission to inpatient psychiatric facilities such as Western State, or detention in jail, and transportation difficulties, particularly problems with Hopelink Transportation, were also mentioned as obstacles to contact.

"Or they run out of minutes. So there can be like… depending on how quickly they use their minutes, it can be weeks before you can get a hold of them again."
-Nurse Care Manager

"They lose their cell phones, they break their cell phones, they don't have any minutes, they change their numbers … I mean it just goes on and on." -Nurse Care Manager

"Their patients are such a loose population of people. Not everyone can be easily gotten a hold of. People don't answer their phones or they can't. They lose their phones, or they don't have a phone." -Clinic Care Coordinator

Social workers described clients' relationship to authority as a hurdle to contact and engagement. The negative opinions and fear they have of government agencies, law enforcement, or any organization that has or has had the perceived ability to disempower them in any way, can be at the forefront of their thinking when they are deciding whether or not to pick up a call that has "City of Seattle" on the caller ID.

"… especially when they see the City of Seattle and making sure, you know, I'm not the police. You know, which bring, brings a great barrier on a lot of our clients in different ethnic communities. So just giving that reassurance that we're here to help them and we're not the police." -Social Worker

"I'm certain that she thought I was a bill collector and that's why I told her one day, I said, 'I'm not a bill collector.' Because she would tell me, 'Oh, she's no here.', and I know in my heart of hearts that I was speaking to her every time … they see the City of Seattle pop up on their, on their caller ID and it's like, 'what is this? Why is the city calling me?'" -Social Worker

Mental Illness and Chemical Dependency. Key informants described the way certain health issues, primarily mental illness and chemical dependency, are frequently significant challenges to client participation. In addition key informants spoke about the difficulties that go along with clients that have serious, complex medical diagnoses.

The symptoms of mental illness, particularly psychosis, pose problems in participation for the clients and providers. With chemical dependency, in addition to the immediate cognitive and sensory effects of substance use that can inhibit active participation in program activities, behaviors related to acquiring and using substances that create general life chaos thwart participation.

> *"When I say mental illness, I mean a lot of them are paranoid, a lot of them have trust issues and lot of them, they're home but they don't answer the phone."*
> *—Nurse Care Manager*

> *"There are, I would say that there's a significant number of personality disordered patients and that, I think those are clients that can be very, very difficult …"*
> *-Administrator*

> *"Yeah, mental illness, chemical dependency. They'll go out on a run and they'll go under the radar for weeks or months at a time and so you just have to keep, you know, trying to contact and knowing that they're going to surface again."*
> *—Nurse Care Manager*

Language and Culture. The last notable threat to client participation in the program mentioned was obstacles related to culture and foreign language. Key informants also mentioned problems with regard to the English language when clients' educational level is not commensurate with assessment tools.

Nurse care managers and social workers explained that non-English speakers, interpreters included, have difficulty translating certain health constructs, such as depression, as well as the complicated English in some of the assessment tools.

> *"I think for a lot of minority communities, the depression is always, the depression section of the assessment is always a challenge. Even with my language, with speaking Spanish, it's very difficult … because it doesn't exist, those words, languages, sentences, in their, in Mexico or Latin America … You know, like for example, 'are you feeling blue?' you know? 'Are you feeling blue today?' Wait, like, I'm not blue. You know?"*
> *-Social Worker*

> *"… on the phone with the language line, and the Cambodian interpreter trying to go through the PAM, it's torture … Neither the client nor the interpreter understands what is this question for? What do you mean? I have to try and re-word it in plain English and it's a very … like yesterday it took me less than 5 minutes to do the PAM, and it can take me over a half an hour to do the PAM on the phone with an interpreter. It's very, very, hard … The post-assessment is the SF-8, which is hard to translate … the depression screen, hard to translate …"   -Social Worker*

Key informants also reported that pure cultural differences, regardless of language, can also be a challenge to clients' active and effective participation in the program, particularly at the

interface of the clients' medical providers and the overarching Western medical model under which they generally operate.

> "… culture plays a lot into that medical model too I think, or you know, or it's in doctor's hands or it's in God's hands and they don't really want to work towards making themselves, you know, in control of their own health. So Doctor, God."
> -Nurse Care Manager

> "But with other cultures, like you don't mention the medical component, you know? You have to mention the curandera, you have to mention, you know, home remedies, whatever."   -Social Worker

Finally, simple access to interpreters due to changes at the State, which funds interpreters for Medicaid recipients, was conveyed as a current challenge.

> "The lack of interpreters. The State is going through major changes with interpreters. That's another big barrier."   -Social Worker

Other challenges mentioned for client participation were the length of the assessment, seen as too long for clients to remain concentrating and fully understanding; the time limitation of the program; ineligibility mid-program due to insurance; and personality conflicts between clients and their assigned care managers.

Challenges with Client Providers

Key informants reported multiple challenges related to the interface with partner clinics and other client providers. Negative provider attitudes and behaviors with regard to clients, most prominently "judgment" and clinic staff professional territorialism were most frequently brought up. Additional identified problems relating to providers were lack of cooperation by some partners, waiting list to establish primary care, waiting at provider appointments, length of wait in scheduling appointments, short length of primary provider appointments, and inexperience of providers.

Provider Attitudes. "Judgment" was the term used most frequently to describe provider attitudes that hinder client progress. Additional descriptives were "blaming", "shaming", "discouraging", "discounting", "punitive", and "racial bias".

> "'What? My client's a high utilizer? I told them not to go to the ER.' Now real strong shaming judgments, and some very delicate ground that we walk on I think with them. Because, I've actually seen them scold their patient or say to me, 'I'm going to talk to that person.' So it is a, you know, 'I'm going to talk to them about this.' "
> -Nurse Care Manager

> "Individual provider attitudes are huge. They make a huge difference if you have judging, shaming, that can come from any area from providers including their own mental health and CD counseling types of things. You know, you're working on, they've gotten to the point of, you know, getting to this very difficult issue for them, and bam,

you know, they're just kind of, shot down I guess. So then you're building them up again. That's very difficult." –Nurse Care Manager

Professional Territorialism. Professional territorialism was expressed as a challenge by both nurses and social workers, who have had a difficult time with providers who are concerned that they are treading on their terrain and possibly duplicating services their patients are already or should be receiving through them. This concern is expressed below by a clinic care coordinator at one of the partner clinics. Key informants did express that as time passes and relationships are built these misunderstandings and professional turf battles tend to diminish.

"There's social worker services through the KCCP program, but some of our patients should really, really be using our social workers' services. So it's like there's a duplication of efforts and I'm thinking, you know, does that make sense? I don't know. I just think, does that make sense? We have somebody here that can work with them." –Clinic Care Coordinator

"… we have seen this reluctance from providers, like, 'Who are you? I'm doing this already. We're duplicating services.'" -Social Worker

"The few interactions that I've had that have been that way have been with the mental health case managers and some of the THS and yeah, you know, I think, like you said, I think they think that we're walking on their toes or trying to take over which we're not trying to do at all. Just trying to coordinate, collaborate. But I think they might feel a little threatened or something. I don't know." –Nurse Care Manager

Holding Clients. A clinic care coordinator also voiced concern that nurse care managers keep patients in the program longer than needed when they, the clinic care coordinators, could be transitioning them to management by the partner clinic.

"So the nurses hold, have held onto some of the clients for a long time."
-Clinic Care Coordinator

Provider Experience. The limited experience of some of the physicians caring for the medically and socially complex RTC clients was troubling to key informants. They identified these providers as relatively new physicians in the community clinics, medical residents at Harborview, and new graduates and staff without adequate credentials in community mental health clinics.

"Our clients, and many people have said this, are some of the most complex, difficult, people to work with, and you have to have sort of your best trained physicians, your internal medicine doctors, your psychiatry professionals, to work with this group. You can't just take the least skilled people like your brand new resident doctor and say "deal with this person who's got five diseases, pancreatic cancer, whatever else."
-Administrator

"You get down to where the RSN is full of a lot of new psychiatrists. They're inexperienced and the kind of clients we have. You can't. You hear the same thing also at Harborview with the residents. These clients need to be with experienced doctors whether it's in the mental health system or primary care." -Administrator

Length of Appointments. This lack of experience coupled with high risk, complex patients is only exacerbated by what key informants see as the inadequate length of primary provider appointments.

"Or people that we see that are homeless and they're actively using, so their needs for each visit is not a ten, fifteen minutes. It's forty-five minutes to an hour and a half." -Social Worker

Waiting. "Waiting" was also a concern of key informants. There are waiting lists to get in to establish care with a primary provider, as well as waiting for appointments for those who are already established in a medical home. Nurses and social workers who accompany clients to appointments also referred to waiting time at actual appointments when providers run behind schedule.

"I mean, right now if you were to call Harborview and try to get an appointment as a new client in the Adult Medicine Clinic, you're going to have an appointment four to six months from now… So, and with somebody with chronic health conditions, you know, congestive heart failure, hypertension, diabetes, they don't need to wait four to six months to get, you know, into a doctor and get, you know, connected." –Social Worker

"So if I'm in medical crisis, or I believe I'm in medical crisis, and I call my doctor and I find out I can't get an appointment for another month and a half, you know." -Social Worker

"They waited an hour or more and then their visit with their physician is only 15 minutes." -Social Worker

Communication and Education about Program. The primary challenge of the program mentioned by the physician providers in the partner clinics was the lack of clear communication about the program and their lack of adequate knowledge about it.

"I think maybe lack of understanding about the program or how to interface." -Physician

"I just wish it was more clearly communicated I guess." -Physician

Systems Challenges

The final and most intractable set of challenges offered by the key informants was challenges embedded in larger systems with which the program interacts, such as the current failing

economy, the overall decentralization of health care, the chemical dependency treatment system, and the mental health system.

Chemical Dependency Treatment. The most frequently mentioned systems challenge was lack of access to chemical dependency treatment, making it difficult to fully engage clients and potential clients in the program.

> *"They're ready to get into treatment. There are no beds. Funding is gone."*
> *-Administrator*

Community Mental Health System/RSN. The bureaucracy and generally inefficient organization of the community mental health system was also mentioned multiple times as a deterrent in clients' optimal participation in the program.

PROGRAM FACILITATORS AND SATISFACTION

Program facilitators, or those elements that help the RTC Program run smoothly and efficiently are largely synonymous with the reasons for satisfaction of the various professionals involved in administering and executing the program.

Innovation

Key informants raved most frequently about the privilege of being involved in such an innovative program that serves as a model for health care in general and care of underserved populations with chronic, complex medical conditions.

> *"I think we might ultimately be on to a very innovative model in terms of how do you provide care management for vulnerable populations and how do you do it so you're both efficient and effective and because the community based model we've developed and ties that we're building to the primary care medical homes I think it could work, so that's exciting to think about." -Administrator*

> *"I think it's an exciting pilot project that can really take off, not only in this state, but in other states with the Medicaid, and there are a lot of states doing different things with their Medicaid population." -Administrator*

Partnerships

They were equally enthusiastic about working within a framework of successful community partnerships and working as part of a team for a common cause.

> *"I think it's very satisfying to go through the stages of team development with a very diverse group of people from the clinics who are looking at things from one vantage point, the nurses are looking at it from another, this cross-functional team, it's fascinating … we have monthly operations meetings, we have yearly retreats and then we have weekly meetings with each of the clinics separately where the clinical teams work together and work on processes and this whole process improvement and*

alignment. Even though it's frustrating and people don't feel like we're getting anywhere, we are. And everybody comes!" -Administrator

"I think the other is that there's a true, we have a true partnership. The organizations that participate strongly share the same mission of serving these vulnerable patients … The people within the clinic systems are all interested and committed. They go the extra yard. They do things they don't have to do. -Administrator

Key informants also appreciated the strong support and leadership they said they receive from their administrative partners, such as DSHS, HRSA, and CHCS, as well as the Medical Director and ADS program administrators.

"There's been a lot of sharing of resources, which again builds trust and a sense of community across a partnership, and some external resources. So the Center for Healthcare Strategies provided the money to pay for the motivational interviewing training." -Administrator

*"Having a leader like ___ makes it possible because they bridge systems and have community recognition and then our leadership here with ____ who's amazing and energetic and supportive. That makes it possible. It wouldn't be possible without these. And then really the State, our State partner has, they don't just sit there. I mean they actually roll up their sleeves and try to change things on their end and get obstacles out of the way to make things work better for us so that makes it possible."
—Administrator*

Talent and Commitment
The good fortune of working with talented, committed colleagues was also seen as an inspiration. Key informants also indicated their admiration and appreciation of the continual learning that routinely translates in to program adaptations, and the skill development of the ADS staff. The experience and expertise of ADS as an agency was seen as fundamental to the ongoing development and success of the program.

"Working with some very talented people is, has been a real grace and also very humbling." -Administrator

"They get more skill. They just get more experienced and I think they really work with that, such that there's sort of an eternal quality improvement cycle that's going on. It's very, very impressive." -Administrator

"The folks at ADS they have an ability to just get across the goal line so to speak. They just, they persevere. There are times when I just think, oh my god, we're never going to get this worked out, and they just keep at it, and they do it well." -Administrator

SUGGESTIONS FOR CHANGE

Key informants suggested multiple changes they believe would benefit the program and its clients. Their suggestions break down in to three main categories: changes to working conditions for ADS staff, the nurse care managers and social workers; changes to the structure of the program; and changes related to the interface with client providers and partner clinics.

Changes for ADS Staff

Caseload. The nurse care managers and social workers uniformly feel that their caseloads are too large to satisfactorily attend to the clients. They give concrete suggestions for more manageable numbers.

> *"How about 35 to 50."* –Nurse Care Manager

> *"Really, an ideal load is around 50-60 and that's, I mean, and I think we, I feel the need to keep letting people know that this is not intensive case management. If we were intensive case mangers, we would have, you know, a load of 15, like, you know, the case managers in Harborview at the ED because that's the type of clientele that we're working with for the most part. So, you know, that's just not realistic."*
> -Nurse Care Manager

> *"Personally, my ideal would be 35 because while it is care management, not case management, as I say, we get these incredibly, intense needs of providers, clients."*
> –Nurse Care Managers

> *"I think if we get like, 10 a month on a regular basis and then spread them out throughout the month and with the nurses."* –Social Worker

Workflow. The caseload burden is exacerbated by the sporadic distribution of large numbers of cases, the lack of consistent structure to their work week, such as no set days and times for meetings, and the obligation to perform "clerical" duties. They believe remedying these problems with consistent, even distribution of cases, regularly scheduled meetings, and adding someone who can take over their clerical duties would result in better client care and less stress.

Technology. The nurses and social workers also believe they could perform their jobs much more efficiently with the updated technology. They expressed multiple times that they need laptops for their work out in the community so they don't waste time entering things in the office computers that they already recorded by hand in the field.

> *"I've had caseloads like this and I've been out all over King County but I always had access to my charts with a laptop. Yeah. So just being able to get the information into the system right away rather than having to be bombarded with paperwork, you know, when you can get to the office to get it there. I think that would be very helpful. It would just make it more efficient."* –Nurse Care Manager

Multidisciplinary. It was also suggested that the name of the assessment be changed from the "Nurse Assessment" to something that reflects its interdisciplinary nature, as the social workers routinely perform part of the assessment, particularly during the initial engagement. It was felt that the name is a reflection of more value on the nursing role.

> *"Don't call it the Nurse Assessment, just call it the Assessment Tool or whatever, and note our little, you know, where you're living and all this other kind of social stuff"*
> *-Social Worker*

> *"I think one of the things that I would like to see a little different is that even though this is a nurse care management program, that the social work is maybe valued as much as the, as the nursing piece." -Social Worker*

Programmatic Changes
Time Extension. Key informants felt that RTC clients might have better, more sustainable outcomes if the program had an indefinite length of time, allowing clients to "transition" whenever they are optimally ready. They also suggested that even more time for the assessment would be helpful for the clients, who often demand a long time to develop enough trust to make disclosures. A clinic coordinator also thought it would work better if the initial assessment was performed by partner clinic staff who might be familiar with clients already established in a medical home.

Transition Standards. Clear transition standards, including transition summaries for the medical home by the nurse care managers were another suggestion, as was weekly clinical data updates produced by ADS.

> *"I think it would help us to have you know somewhat more, better articulated, standardized, objective criteria that we can sort of go through to say, like a checklist, where yes, no. We don't have that I think right now we're probably a bit too much gestalt." -Administrator*

> *"So it helps when the nurses put, summarize the goals and summarize what they're working on and the goals that they've met, that way I have a clear snapshot and clear direction on how I can impact, how I can help and be the most effective."*
> *–Clinic Care Coordinator*

Prevention. Key informants also called for more of a focus on prevention in future program design, so the clients do not begin the program in such dire medical and social situations.

> *"That would be very satisfying, knowing that you could actually start working with people before they ruined things to the point where it's very difficult."*
> *–Clinic Care Coordinator*

Changes with Client Providers
Many proposals for change regarding client providers and partner clinics were made. Increasing marketing and education about the program to providers was most frequently mentioned.

Providers requested more consistent updates about their patients involved in the RTC Program. They also mentioned that the simple effort of flagging all the patients who are involved in the program in their databases would make active participation easier for them.

Education and Updates.

> *"More education or explanation to providers … you know, more the interface between the, our clinic, or any specific clinic I guess, providers and the actual program so we can figure it out."* -Physician

> *"I wouldn't be sitting there on any given Wednesday thinking you know I want to do this, but if I hear something happened, then I'd like to respond, or at least know about it and like to get some sort of … a communication stream, a sheet of paper, or something … So I guess if there's something to improve about the program it would be to improve inter-visit communication. Yeah, updates and solicitations of opinion between visits."* -Physician

Additional Partner Clinics. Key informants offered that several clinics with which they have had good experiences and also have shorter waits for establishing primary care and scheduling appointments should be added as partner clinics.

> *"I think that the other thing that will be really nice and helpful, is that we're punting so many clients to Swedish these days and so Swedish should be one of our partners … if I were to call Swedish Family Medicine today, I could have a new client appointment for you next week."* -Social Worker

Fostering mental health integration, and collaborating with emergency departments that are frequented by RTC Program clients were other suggestions.

Physicians acknowledged that the length of their appointments are too short for patients' needs in general, regardless of medical complexity, but suggested that since appointment length is embedded as part of the system and not likely something they can easily change, to develop a strategy of encouraging patients to make more frequent appointments. They also thought that including at least one male nurse case manager would be advantageous for certain clients.

IV.   Recommendations

In this section, we provide a set of recommendations identified by CHAMMP but based on and informed by key informants' accounts. All have been provided for stakeholder consideration. We believe that the recommendations, although presented independently, can be interrelated. For example, as one nurse care manager observed, enhancing technology could increase efficiency considerably, thereby impacting the extent to which caseloads would need to be reduced. Thus, we suggest that recommendations be considered as a starting point for thinking about a variety of interdependent ways to make improvements to the RTC Program. Some recommendations may have fiscal impact but since we did not interview funders in this study,

we could not take this into consideration in making the recommendations,   Again, we emphasize, the recommendations are provided for stakeholder consideration only.

Multidisciplinary Refinement

As the program has progressed its execution has become more multidisciplinary, increasingly involving social workers in the initial engagement and assessment, and intervention. The program has also brought more focus to psychosocial issues, such as meeting basic needs like housing, and mental health and chemical dependency. The nurses and social workers at times work outside their core competencies, such as nurses addressing psychosocial, mental health or chemical dependency issues, and social workers performing clerical duties. Providing a framework in which the nurses and social workers practice primarily within their roles in the program would increase productivity and efficiency. In addition, clerical support is needed. In this division of labor, retaining the central support and leadership of the nurse care manager is important because key informants identified this targeted support of a "go to" person as one of the most essential ingredients of the intervention.

Caseload and Work Flow

Nurse care managers gave suggestions of maintaining caseloads between 35 and 50 clients. They also communicated that if work flow issues were addressed they could be much more effective with large caseloads. Given these comments, it appears that some kind of consistent, steady case flow and weekly meeting schedule would improve the nurse care managers' and social workers' ability to execute the program properly for clients.

Technology

A number of comments from nurse care managers and social workers suggest they are needlessly challenged with inadequate technology. In the field they have no online access so they have to enter everything, including assessments, into the database when they return to ADS. For a busy program, laptops they could take with them in the community would save much time. If they do not have program cell phones this would also allow them to multi-task in the field and save time. A Global Positioning System (GPS) would also help in navigating across the county, where they consistently make many visits to places they have never been. These are relatively inexpensive items yet they could make a significant difference in staff productivity, efficiency, and morale.

The other burden not only on the nurse care managers' and social workers' time, but the clinic care coordinators and patient providers as well, is inability to share information about patients cross-institutionally over email. The proposed new data system may remedy this but, in the interim, it would be important to identify ways to share such information immediately. One possibility is to assign client numbers so patients do not have to be identified by name in emails.

Clients also have technology insufficiencies, mainly that they often lack consistent phone contact due to homelessness, finances, or lifestyle. It would be reasonable to consider the option of providing them with disposable time-limited cell phones at any period during which lack of contact would make or break successful participation in the program.

Assessment and Evaluation

Many key informants mentioned the importance of the clinical evaluation, and also the difficulty of adapting the initial and post assessment tools, particularly the PAM, across language and culture. Investigating whether there are validated instruments for other populations and languages for the PAM and the other assessment instruments in combination with fortifying clinical evaluation by standardizing it would be strengthen assessment and evaluation as a whole.

Education and Marketing

The physicians uniformly communicated that they did not feel fully informed about the RTC Program. They also expressed an understanding of the program that reflected the hierarchical medical model of clinic culture that diverged somewhat from the collaborative, client-centered RTC philosophy. More consistent education and marketing about the program would help reduce this culture clash, allow physicians to take optimal advantage of the program, encourage collaboration so the clinics can work in concert with it, and mitigate the professional territorialism the nurse care managers and social workers say they encounter.

In addition to an explanation about the process and mission of the program, a core piece of the education should be about the underlying core concepts driving the RTC Program: care management and MI. Both these are built on strengths-based, client-driven philosophies. Understanding the big picture and core concepts of the program is the door to more productive systems collaboration and change, and better results for clients.

Consideration should be give to expanding education and marketing beyond the community clinic system to the mental health and chemical dependency systems as well. RTC has been able to fast-track clients' psychosocial needs such as housing through Section 8, and it is possible in building consistent relationships through marketing, that crucial client needs such as chemical dependency detoxification and treatment could also eventually be fast-tracked.

Transition

Key informants suggested several ideas for change regarding clients' transition out of the RTC Program. Clinic care coordinators requested client summaries at the transition period since it is so difficult to obtain information from the current database. Standardizing the transition procedure, including identifying criteria to determine when the client is ready, was also an important suggestion.

Dependency on the nurse care managers, after having their support for twelve months, was mentioned multiple times as a potential disadvantage to clients. Some key informants suggested extending the program indefinitely. Given the variability in client needs, it may also be important to consider constructing a transition protocol that has the ability to be individually customized. For example, creating a protracted transition option based on individual client needs would allow those who have less self-efficacy, social support, or other factors that make it difficult to transition, to go through incremental steps that more slowly taper contact while helping to increase whatever resources or skills they are lacking for successful transition.

Provider Clinics

Adding primary care clinics to the program that already see clients from the program and have less wait time for appointments than the burdened community clinics would benefit RTC clients. Also, clinic physicians pointed out that their time allotment for clinic visits is short and is not likely to change in the near future. Developing a strategy for accommodating this reality is worth considering: more frequent visits may be one alternative.

Physicians voiced that they would like regular updates about their patients in the RTC Program. This could be accomplished possibly through email or the new data system and would help physicians stay more involved in the program and their RTC patients' overall care, and coordinate more effectively with other client providers. These updates could also go out to clients' mental health, chemical dependency, and specialty providers, fostering attention to coordination going before the program ends.

Data System

The current data system and general dissatisfaction with it was mentioned more than any other topic in the key informant interviews with the exception of motivational interviewing. As the new data system is being designed, several elements should be considered as part of its composition.

- Because the intervention has become increasingly multidisciplinary, equal and flexible access to the initial assessment additional information would help streamline the combined efforts of the nurse care managers and social workers in the most efficient way possible.

- Partner clinic physicians indicated that they would like updates on clients.   Developing a standard format for client updates as well as a protocol for transmitting this information to physicians and possibly other providers such as mental health and specialists should be considered as an important element of the new data system.

- Clinic care coordinators indicated that they would like client summaries at the transition. Developing a standard format for a transition summary should also be considered as a component.

- Considering that cross-institutional communication by email is a challenge, creating a data system that allows extensive enough documentation and updates that need for email communication about clients is minimized would cut down on the time and complex strategies nurse care managers, and clinic care coordinators are currently using.
- For information and records in which detailed narrative is not necessary or standardization is optimal, providing several options requiring minimal data entry would save time and increase efficiency.

Future Study and Focus

Key informants spoke about the way the program intervention is slowly transforming the system as it makes small incremental adaptations in response to the RTC Program and brings

together parties from all parts of the health care system for collaboration. We believe it would be fruitful to study this system change and how it is evolving, as it is an essential element of the impact of the intervention and on the cutting edge of health care delivery. We recommend that future evaluation efforts incorporate this focus.

Focusing on building mental health integration, particularly considering the difficulties in the mental health system, would reduce some significant client barriers to participation. Also, despite the program's effort to reduce emergency department visits, emergency departments continue to be a large part of this client population's care, particularly when they are just starting the program and have fewer skills, tools and resources. Collaborating and coordinating with emergency departments in a similar way as the program currently collaborates with clinics could add another beneficial layer to the intervention.

Finally, many key informants emphasized the individual nature of clients' accomplishments in the program and spoke about wonderful success stories they hear. Such stories have the ability to powerfully communicate the impact of the program to a broad range of stakeholders. As such, the program should consider collecting and compiling client success stories in a format that can be easily shared with others.

V.   References

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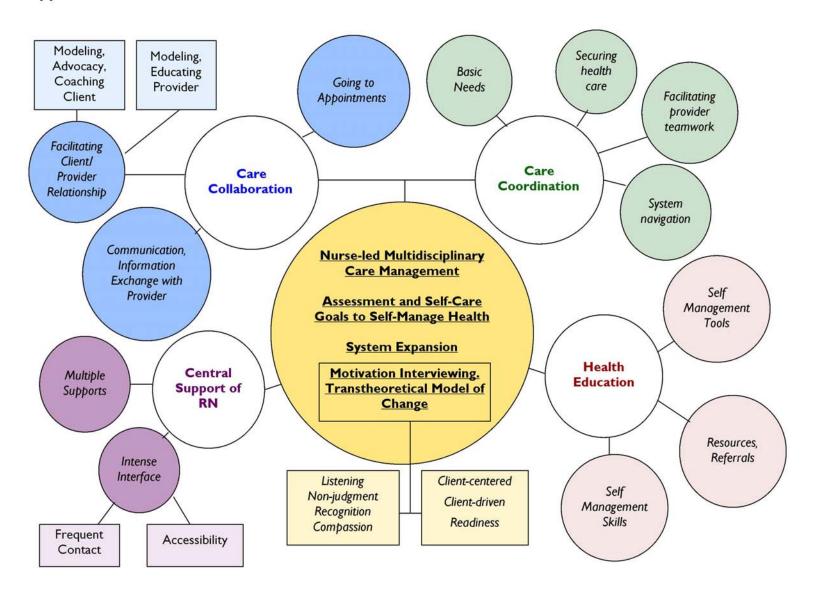
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Appendix A: RTC Key Informant Interview Questions

RN Care Managers & Social Workers Focus Groups	Administrators Individual Interviews	Primary Care Providers & Clinic Care Coordinators Individual Interviews
Can you briefly describe your role in the King County Care Partners Rethinking Care Program (begun February 2009)?	Can you briefly describe your role in the King County Care Partners Rethinking Care Program (begun February 2009)?	Can you briefly describe your role in the King County Care Partners Rethinking Care Program (begun February 2009)?
In your own words, what *IS* the King County Care Partners Rethinking Care Program?	In your own words, what *IS* the King County Care Partners Rethinking Care Program?	In your own words, what *IS* the King County Care Partners Rethinking Care Program?
What is the process a client goes through in the program (starting with recruitment)?	What is the process a client goes through in the program (starting with recruitment)?	
On an average day, how do you spend your time?	On an average day, how do the nurse care managers and social workers spend their time?	
Can you describe the assessment process? Has it changed over time? Is the PAM a useful tool in the assessment process? What new or different information does it provide?	Can you describe the assessment process? Has it changed over time? Is the PAM a useful tool in the assessment process? What new or different information does it provide?	
How would you describe the "intervention" of the King County Care Partners Rethinking Care Program? Has it changed over time?	How would you describe the "intervention" of the King County Care Partners Rethinking Care Program? Has it changed over time?	How would you describe the "intervention" of the King County Care Partners Rethinking Care Program? Has it changed over time?
Are there benefits of the program for clients? Are there disadvantages of the program for clients? What are they?	Are there benefits of the program for clients? Are there any disadvantages of the program for clients? What are they?	Are there benefits of the program for your patients? Are there any disadvantages of the program for your patients?
What parts of the program are most helpful or have the greatest impact for the clients? What parts of the program are least helpful to clients?	What parts of the program are most helpful or have the greatest impact for the clients? What parts of the program are least helpful to clients?	What parts of the program are most helpful or have the greatest impact for your patients? What parts of the program are least helpful to your patients?
How do you assess client improvement? Do you repeat the PAM for this?	How do you assess client improvement? Do you repeat the PAM for this?	
Can you identify any characteristics of clients who are more likely to improve or be successful in the program?	Can you identify any characteristics of clients who are more likely to improve or be successful in the program?	Can you identify any characteristics of your patients who are more likely to improve or be successful in the program?
Are there things that facilitate administering the program (make it easy)?	Are there things that facilitate administering the program (make it easy)?	Are there things that facilitate your participation in the program (make it easy)?

RN Care Managers & Social Workers Focus Groups	Administrators Individual Interviews	Primary Care Providers & Clinic Care Coordinators Individual Interviews
Are there things that make it challenging to administer the program?	Are there things that make it challenging to administer the program?	Are there things that make your participation in the program challenging?
		Are there things that make your patients' participation in the program challenging?
Are there specific things that you think would make it easier for you to administer the program?	Are there specific things that you think would make it easier for you to administer the program?	Are there specific things that you think would make it easier for you and your patients to participate in the program?
Are there things that facilitate client retention in the program?

Are there things that impede client retention? | Are there things that facilitate client retention in the program?

Are there things that impede client retention? | Are there things that facilitate patient retention in the program?

Are there things that impede patient retention? |
| Are there things that facilitate clients' involvement in their own care in the program?

Are there things that impede clients' involvement in their own care? | Are there things that facilitate clients' involvement in their own care in the program?

Are there things that impede clients' involvement in their own care? | Are there things that facilitate patients' involvement in their own care in the program?

Are there things that impede patients' involvement in their own care? |
| Are there ways you engage clients in the program? Have they changed over time?

Does the PAM provide helpful information for engaging clients? | Are there ways your staff engages clients in the program? Have they changed over time?

Does the PAM provide helpful information for engaging clients? | |
What has your experience of collaborating with collateral health professionals been? Are there ways it has been easy? Are there ways it has been challenging?		
Were you trained in motivational interviewing as part of the program? What has your experience of being trained in motivational interviewing for the program been? Has it impacted your work with program clients?		Were you trained in motivational interviewing as part of the program? What has your experience of being trained in motivational interviewing for the program been? Has it impacted your work with program clients?
What are some things you like best about the Rethinking Care Program or your role in it?	What are some things you like best about the Rethinking Care Program or your role in it?	What are some things you like best about the Rethinking Care Program or your role in it?
What are some things you like least about the Rethinking Care Program or your role in it?	What are some things you like least about the Rethinking Care Program or your role in it?	What are some things you like least about the Rethinking Care Program or your role in it?
Are there things you would change about the Rethinking Care Program?	Are there things you would change about the Rethinking Care Program?	Are there things you would change about the Rethinking Care Program?

Appendix B: RTC Intervention

Modeling, Advocacy, Coaching Client

Modeling, Educating Provider

Facilitating Client/ Provider Relationship

Going to Appointments

Basic Needs

Securing health care

Facilitating provider teamwork

Care Collaboration

Care Coordination

System navigation

Communication, Information Exchange with Provider

Nurse-led Multidisciplinary Care Management

Assessment and Self-Care Goals to Self-Manage Health

System Expansion

Motivation Interviewing. Transtheoretical Model of Change

Self Management Tools

Multiple Supports

Central Support of RN

Health Education

Resources, Referrals

Intense Interface

Listening Non-judgment Recognition Compassion

Client-centered Client-driven Readiness

Self Management Skills

Frequent Contact

Accessibility

Appendix C: RTC Process Flowchart

HRSA identifies eligible clients through predictive modeling

HRSA sends letters to eligible clients stating they are eligible for a free program (RTC) and will be contacted

HRSA sends list of eligible clients who received letters about RTC Program to King County ADS

ADS engagement social worker gathers preliminary information on client

- Financial eligibility
- Clinic affiliation
- Medical records for current diagnoses and medications
- Additional preliminary information found in various databases

Social worker calls eligible clients for initial engagement

- Explains program and its benefits
- Starts assessment: demographics SF8 health risk assessment, psychosocial information
- Confirms preliminary information gathered before initial contact with client
- Invites the client to participate
- Client enrolls
- Explains that nurse care manager will call them within two weeks

Name of enrolled client sent to ADS clinical nurse supervisor who checks for potential red flags relating to client participation and staff safety, assigns client to a nurse care manager

Nurse contacts client by phone to schedule face to face visit, ideally at home, sends client letter if unable to reach by phone

- Continues comprehensive assessment of medical and mental health history and validated instruments
- Start development of mutual self-care goals and identification of resources and support needed to complete them
- Plan clinic visit

Initial visit at home, clinic, or in public space continues assessment process and intervention

Bring in social work if needed

Introduce client's clinic care coordinator

Client has progressed on self-care goals and built some self-management skills, or has been in the program more than 12 months

Clinic care coordinator

- Provides regular outreach to client
- Makes sure they are keeping appointments
- Provides general support

Transition to clinic care coordinator at medical home